FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042275

Facility Name: Zachary House

Address: 1100 East Avenue (Number) Streamwood (City) 60107 (Zip Code)

County: Cook

Telephone Number: (630) 483-0537 **Fax #** (630) 483-0537

IDPA ID Number:

Date of Initial License for Current Owners: 12/16/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Jean Adaskivich **Telephone Number:** (630) 483-0537

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Jean Adaskivich
(Title) Administrator

Paid Preparer

(Signed) March 11, 2003 (Date)
(Print Name and Title) Robert Rein, Practitioner
(Firm Name & Address) Robert Rein, CPA, P.O. Box 201, Morton, Illinois 61550-0201
(Telephone) (309) 266-8178 **Fax #** ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Zachary House # 0042275 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,548			5,548	13
14	TOTALS	5,548			5,548	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.00%

D. How many bed-hold days during this year were paid by Public Aid? 168 **(Do not include bed-hold days in Section B.)**

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/16/96

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 12/16/96 NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 **Fiscal Year:** 12/31/2002

*** All facilities other than governmental must report on the accrual basis.**

Facility Name & ID Number Zachary House # 0042275 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	35,079	1,363	1,680	38,122	(2,185)	35,937	6,190	42,127			1
2	Food Purchase		17,393		17,393		17,393		17,393			2
3	Housekeeping	5,046	260		5,306		5,306		5,306			3
4	Laundry		1,361		1,361		1,361		1,361			4
5	Heat and Other Utilities			12,538	12,538		12,538		12,538			5
6	Maintenance	13,000	6,189	6,092	25,281		25,281		25,281			6
7	Other (specify):*											7
8	**TOTAL General Services**	53,125	26,566	20,310	100,001	(2,185)	97,816	6,190	104,006			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	147,169	1,748	6,683	155,600	(3,482)	152,118		152,118			10
10a	Therapy					390	390		390			10a
11	Activities		424		424		424		424			11
12	Social Services			438	438	1,390	1,828		1,828			12
13	Nurse Aide Training					4,082	4,082		4,082			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	147,169	2,172	7,121	156,462	2,380	158,842		158,842			16
	C. General Administration											
17	Administrative	36,651			36,651		36,651	50,901	87,552			17
18	Directors Fees											18
19	Professional Services			4,304	4,304	(82)	4,222		4,222			19
20	Dues, Fees, Subscriptions & Promotions			1,505	1,505		1,505		1,505			20
21	Clerical & General Office Expenses		986	54,979	55,965	(13)	55,952	(25,019)	30,933			21
22	Employee Benefits & Payroll Taxes			47,130	47,130	2,280	49,410	9,579	58,989			22
23	Inservice Training & Education											23
24	Travel and Seminar			90	90		90		90			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice							8,079	8,079			26
27	Other (specify):*											27
28	**TOTAL General Administration**	36,651	986	108,008	145,645	2,185	147,830	43,540	191,370			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	236,945	29,724	135,439	402,108	2,380	404,488	49,730	454,218			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Zachary House 0042275 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation					(3)	(3)	15,206	15,203			30
31	Amortization of Pre-Op. & Org.					3	3		3			31
32	Interest							26,214	26,214			32
33	Real Estate Taxes							36,944	36,944			33
34	Rent-Facility & Grounds			124,308	124,308		124,308	(124,308)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			124,308	124,308		124,308	(45,944)	78,364			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			2,380	2,380	(2,380)						39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			47,327	47,327		47,327		47,327			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			49,707	49,707	(2,380)	47,327		47,327			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	236,945	29,724	309,454	576,123		576,123	3,786	579,909			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Zachary House # 0042275 **Report Period Beginning:** 01/01/2002 **Ending:** 2/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	12,456	30.3		9
10	Interest and Other Investment Income	(3,487)	32.3		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(5,183)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 11,719		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(7,933)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (7,933)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 3,786		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Facility Name & ID Number Zachary House **#** 0042275 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	**Ownership %**	**Name**	**City**	**Name**	**City**	**Type of Business**
Byrn T. Witt	50%	Meadows	Rolling Meadows			
Barbara S. Witt	50%	Meadows	Rolling Meadows			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] **YES** [ ] **NO**

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Administrative	$	Meadows		$ 12,000	$ 12,000	1
2	V	17	Administrator		Meadows		10,461	10,461	2
3	V	17	Chief Financial Officer		Meadows		28,440	28,440	3
4	V	1	Dietary Manager		Meadows		6,190	6,190	4
5	V	21	Personnel, Accounting, Etc.		Meadows		16,636	16,636	5
6	V	21	General Office Supplies		Meadows		2,282	2,282	6
7	V	21	General Office Other		Meadows		6,463	6,463	7
8	V	22	Employee Benefits		Meadows		9,579	9,579	8
9	V	21	Administrative Overhead	50,400	Meadows			(50,400)	9
10	V	34	Facility Rent	124,308	Byrn T. Witt & Barbara S. Witt	100.00%		(124,308)	10
11	V	32	Interest		Byrn T. Witt & Barbara S. Witt	100.00%	29,701	29,701	11
12	V	26	Insurance		Meadows		8,079	8,079	12
13	V	33	Real Estate Tax		Byrn T. Witt & Barbara S. Witt	100.00%	36,944	36,944	13
14	**Total**			$ 174,708			$ 166,775	$ * (7,933)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Zachary House # 0042275 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Byrn T. Witt		Administrator	50%		4.8	40%	Salary	$ 12,000	17.3	1
2	Robin Witt	Chief Financial Officer	Administration	-0- %		16	40%	Salary	28,440	17.1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 40,440		13

* **If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

** **This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number Zachary House # 0042275 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Meadows
Street Address 3250 South Plum Grove Road
City / State / Zip Code Rolling Meadows, IL 60008
Phone Number (847) 397-0055
Fax Number (847) 397-0477

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17.1	Administrator	Direct Cost	1,994	2	$ 57,301	$ 57,301	364	$ 10,461	1
2	21.1	Office	Direct Cost	6,274	2	118,103	118,103	884	16,636	2
3	17.1	CFO	Direct Cost	2,080	2	71,100	71,100	832	28,440	3
4	1.1	Dietary	Direct Cost	1,020	2	15,182	15,182	416	6,190	4
5	21.2	Office Supplies	Expenses	2,104,379	2	14,161		339,178	2,282	5
6	21.3	Office Other	Expenses	2,104,379	2	40,099		339,178	6,463	6
7	22.3	Employee Benefits	Salary	2,138,587	2	331,870		61,727	9,579	7
8	26.3	Insurance	Expenses	2,104,379	2	50,126		339,178	8,079	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 697,942	$ 261,686		$ 88,130	25

Facility Name & ID Number Zachary House # 0042275 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2	CitiBank		X	Building Construction	4,176.00	03/09/97	460,000	395,737	03/09/17	6.75%	27,308	2
3	CitiBank		X	Building Construction	1,335.39	01/27/97	83,000	18,868	02/01/04	9.00%	2,393	3
4									Interest Income Adjustment		(3,487)	4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**				$5,511.39		$ 543,000	$ 414,605			$ 26,214	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$ 543,000	$ 414,605			$ 26,214	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Zachary House # 0042275 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$ 43,376	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 40,160	2
3. Under or (over) accrual (line 2 minus line 1).	$ (3,216)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 40,160	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 36,944	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	41,720	8
1998	42,383	9
1999	42,733	10
2000	43,376	11
2001	40,160	12

Accrual based on County estimate.

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13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Zachary House COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042275

CONTACT PERSON REGARDING THIS REPORT Jean Adaskivich

TELEPHONE (630) 483-0537 FAX #: (630) 483-0537

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-25-301-043-0000	1102 East Avenue	$ 40,160	$ 40,160
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 40,160.00	$ 40,160.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Zachary House # 0042275 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. **Square Feet:** 4,680 **B. General Construction Type:** **Exterior** Brick & Siding **Frame** Wood **Number of Stories** One

C. **Does the Operating Entity?** [ ] **(a) Own the Facility** [x] **(b) Rent from a Related Organization.** [ ] **(c) Rent from Completely Unrelated Organization.**

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. **Does the Operating Entity?** [x] **(a) Own the Equipment** [x] **(b) Rent equipment from a Related Organization.** [ ] **(c) Rent equipment from Completely Unrelated Organization.**

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. **List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).**

F. **Does this cost report reflect any organization or pre-operating costs which are being amortized?** [X] **YES** [ ] **NO**
If so, please complete the following:

1. Total Amount Incurred: 425 **2. Number of Years Over Which it is Being Amortized:**

3. Current Period Amortization: 3 **4. Dates Incurred:** Pre-December 16, 1996.

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	ICF/DD 16	52,695	16-May-95	$ 145,000	1
2					2
3	TOTALS	52,695		$ 145,000	3

Facility Name & ID Number Zachary House # 0042275 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1996	1996	$ 509,864	$	39	$ 13,073	$ 13,073	$ 78,438	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscaping			1997	16,650		39	427	427	2,399	9
10	Time Clock Sytem			1999	1,057		5	211	211	651	10
11	Floor Covering			2002	2,985	970	7	70	(900)	70	11
12	Wall Covering			2002	672	218	7	16	(202)	16	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Zachary House # 0042275 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37									37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	**TOTAL (lines 4 thru 69)**		$ 531,228	$ 1,189		$ 13,797	$ 12,608	$ 81,574	70

****Improvement type must be detailed in order for the cost report to be considered complete**

Facility Name & ID Number Zachary House # 0042275 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 29,289	$ 770	$ 770	$	5	$ 28,149	71
72	Current Year Purchases	551	262	110	(152)	5	110	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 29,840	$ 1,032	$ 880	$ (152)		$ 28,259	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	97 Dodge Ram Wagon Van	10/03/96	$ 24,645	$	$	$	5	$ 24,645	76
77	Patient Transport	2001 Dodge Van	09/11/01	26,365	529	529		5	5,802	77
78										78
79										79
80	TOTALS			$ 51,010	$ 529	$ 529	$		$ 30,447	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 757,078	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 2,750	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 15,206	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 12,456	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 140,280	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Zachary House # 0042275 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____ .

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Zachary House # 0042275 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [x]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [x]
- HOURS PER AIDE 80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		24		24
3	Classroom Wages (a)		752		752
4	Clinical Wages (b)		1,505		1,505
5	In-House Trainer Wages (c)		1,201		1,201
6	Transportation				
7	Contractual Payments		600		600
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 4,082	$	$ 4,082
10	SUM OF line 9, col. 1 and 2 (e)	$ 4,082			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Zachary House **STATE OF ILLINOIS** # 0042275 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.3	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39.2								12
13	Other (specify): Medical Supplies	39.2								13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Zachary House # 0042275 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 296,935	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	100,102		3
4	Supply Inventory (priced at FIFO)	183		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	499,637		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 896,857	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	(1,141)		15
16	Equipment, at Historical Cost	52,142		16
17	Accumulated Depreciation (book methods)	(28,077)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	425		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(364)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 22,985	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 919,842	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (7,416)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	(2,247)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (9,663)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (9,663)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (910,179)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (919,842)	$	48

***(See instructions.)**

Facility Name & ID Number Zachary House # 0042275 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	**$** 744,245	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 744,245	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	165,934	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 165,934	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 910,179	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Zachary House # 0042275 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ (738,570)	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ (738,570)	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	(3,487)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (3,487)	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous		28
28a	Loss on Sale of Fixed Assets		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ (742,057)	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	100,001	31
32	Health Care	156,462	32
33	General Administration	145,645	33
	B. Capital Expense		
34	Ownership	124,308	34
	C. Ancillary Expense		
35	Special Cost Centers	2,380	35
36	Provider Participation Fee	47,327	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 576,123	40
41	**Income before Income Taxes (line 30 minus line 40)****	(165,934)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (165,934)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Zachary House # 0042275 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11	11	245	22.28	3
4	Licensed Practical Nurses	734	745	12,057	16.18	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician	416	416	6,190	14.88	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	1,859	2,098	35,079	16.72	15
16	Dishwashers					16
17	Maintenance Workers	1,043	1,065	13,000	12.21	17
18	Housekeepers	570	570	5,046	8.85	18
19	Laundry					19
20	Administrator	2,111	2,307	47,112	20.42	20
21	Assistant Administrator					21
22	Other Administrative	832	832	28,440	34.18	22
23	Office Manager					23
24	Clerical	884	884	16,636	18.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	9,908	10,687	134,867	12.62	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	**TOTAL (lines 1 - 33)**	18,368	19,615	$ 298,672 *	$ 15.23	34

* **This total must agree with page 4, column 1, line 45.**

** **See instructions.**

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	48	$ 1,680	1.3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	200	6,683	10.3	38
39	Pharmacist Consultant	11	600	10.3	39
40	Physical Therapy Consultant	3	150	10a.3	40
41	Occupational Therapy Consultant	3	180	10a.3	41
42	Respiratory Therapy Consultant	1	60	10a.3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	3	90	12.3	45
46	Other(specify)				46
47	Behavioir Dev'l Consultant	13	1,300	12.3	47
48					48
49	**TOTAL (lines 35 - 48)**	282	$ 10,743		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	**TOTAL (lines 50 - 52)**		$		53

Facility Name & ID Number Zachary House # 0042275 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jean Adaskivich	Administrator	-0-	$ 10,461
Donita Lyle-Link	Administrator	-0-	36,651
Robin Witt	CFO	-0-	28,440
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 75,552

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Bell, Boyd, & Lloyd	Legal	$ 329
Robert Rein, CPA	Consulting	2,933
Clifton Gunderson	Accounting	119
John Fritzger	Legal	606
Precise Records	Consulting	77
Reclassification		82
Information Control		158
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		**$** 4,304

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 8,878
Unemployment Compensation Insurance	1,918
FICA Taxes	21,229
Employee Health Insurance	12,853
Employee Meals	2,185
Illinois Municipal Retirement Fund (IMRF)*	
Staff Appreciation	100
Employee Life/Disability	318
Dental Insurance	1,833
Allocation of Employee Benefits	9,579
Employee Physicals	95
TOTAL (agree to Schedule V, line 22, col.8)	$ 58,989

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		**$**

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	846
Health Care Worker Background Check	26
(Indicate # of checks performed 2)	
Secretary of State	127
Daily Herald Newspaper	106
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,505

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	90
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 90

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Zachary House # 0042275 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Zachary House # 0042275 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ N/A Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease. No

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 47,327
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 2,185 Has any meal income been offset against related costs? No Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.